STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395050	A. BLDG: 00 B. WING:	05/01/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
GARVEY MANOR STATE LICENSE NUMBER: 070202	1037 SOUTH LOGAN BOULEVARD HOLLIDAYSBURG, PA 16648

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a complaint survey and incident survey completed on May 1, 2023, it was determined that Garvey Manor was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0658 SS=D		F 0658		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0658 SS=D	Continued from page 1 483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 0658	Resident #2 was assessed by a Registered Nurse Supervisor on 4/26/23 at 9:15am to ensure that no abnormalities or changes in condition were noted. A therapy screen was completed on 4/26/23 and Resident #2 remained assist of two with gait belt for transfers and non-ambulatory. The Registered Nurse and Licensed Practical Nurse that responded to Resident 2's fall were educated on the night of 4/26/23 of the definition of a fall and the immediate intervention required following a fall. Education with all certified and licensed nursing staff began 5/4/23 to ensure that staff were aware of the definition of a fall, and the immediate required assessment by a Registered Nurse following a fall to ensure that this deficient practice does not occur with any other residents. This education will be completed with staff as they are scheduled to work. Agency orientation on the nursing units for certified and licensed staff was increased to include an additional eight hours of orientation.	Completion Date: **06/01/2023** Status: **APPROVED** Date: **05/15/2023**

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F 0658 SS=D	Continued from page 2	F 0658	Registered Nurse staff will be re-educated on how to handle falls and the importance of assessing change in condition. Audits of immediate assessment from a Registered Nurse will occur with all falls for four weeks and then five falls per month for two months. Corrective action will be completed 6/1/23.	

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F 0658 SS=D	Continued from page 3 Based on review of The Pennsylvania Code, Professional and Vocational Standards, State Board of Nursing, facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a registered nurse assessment was completed with a change in condition for one of three residents reviewed (Resident 2). Finding include: The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicated that the registered nurse was to collect complete and ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain and restore the well-being of individuals. The facility's current policy for falls indicated that a	F 0658		

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F 0658 SS=D	Continued from page 4	F 0658		

registered nurse would assess any resident after a fall prior to the resident being moved.

A comprehensive Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated April 5, 2023, revealed that the resident had severe cognitive impairment, was sometimes understood, could sometimes understand, was dependent on staff for her locomotion on and off the unit, and had diagnoses of dementia. Resident 2's care plan, dated February 16, 2023, indicated that the resident required two staff to pivot with a gait belt and a wheeled walker for transfers.

Nursing note for Resident 2, dated April 26, 2023 at 6:06 a.m., revealed that the resident was walking with Nurse Aide 1 when she stated that she was "going down." The nurse aide then lowered the resident to the floor. The resident was then lifted from the floor with a full body mechanical lift by a licensed practical nurse and nurse aide and placed in bed.

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F 0658 SS=D	Continued from page 5 Interview with the Director of Nursing on May 1, 2023, at 1:50 p.m. confirmed that a registered nurse did not assess the resident prior to the staff picking her up off the floor and putting her back in bed and should have. 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0658		
F 0689 SS=D		F 0689		

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F 0689 SS=D	Continued from page 6 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	Resident #2 was assessed by a Registered Nurse Supervisor on 4/26/23 at 9:15am to ensure that no abnormalities or changes in condition were noted. A therapy screen was completed on 4/26/23 and Resident #2 remained assist of two with gait belt for transfers and non-ambulatory. Education with all certified and licensed nursing staff began 5/4/23 to ensure that staff were aware of the definition of a fall, and the immediate required assessment by a Registered Nurse following a fall, definition of neglect and consequences of substantiated neglect to ensure that this deficient practice does not occur with any other residents. This education will be completed with staff as they are scheduled to work. On 4/26/23, the agency Certified Nurse Aide was made aware of the facility's concern, was interviewed, and was informed that she will no longer be used in the facility due to substantiated neglect to prevent this from occurring again. Changes were implemented with the orientation of agency nursing staff	Completion Date: **06/01/2023** Status: **APPROVED** Date: **05/15/2023**

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F 0689 SS=D	Continued from page 7	F 0689	to Garvey Manor. Moving forward, the education will be given by the Staff Development team member that is doing the "office orientation" as well as the floor staff who is completing the "floor orientation" with the agency staff. All current certified and licensed staff including agency staff will receive re-education of the importance of following the Activity of Daily Living directive and it will continue to be presented to all new staff upon orientation to the facility. In addition, agency orientation on the nursing units for certified and licensed staff was increased to include an additional eight hours of orientation. Audits of adherence to the Activity of Daily Living directive will occur with direct care for five residents a week for four weeks and then five residents per month for two months. Corrective action will be completed 6/1/23.	

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F 0689 SS=D	Continued from page 8 Based on a review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's plan of care was followed for fall prevention and transfers for one of three residents reviewed (Resident 2). Findings include: A comprehensive Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated April 5, 2023, revealed that the resident had severe cognitive impairment, was sometimes understood, could sometimes understand, was dependent on staff for her locomotion on and off the unit, and had diagnoses of dementia. Resident 2's care plan, dated February 16, 2023, indicated that the resident required two staff to pivot with a gait belt and a wheeled walker for transfers. Nursing note for Resident 2, dated April 26, 2023 at 6:06 a.m., revealed that the resident was walking	F 0689		

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F 0689 SS=D	Continued from page 9 with Nurse Aide 1 when she stated that she was "going down." The nurse aide then lowered the resident to the floor. Interview with the Director of Nursing on May 1, 2023, at 1:50 p.m. confirmed that Resident 2 was transferred with one assist and not a two-person assist for transfers as care planned. 28 Pa. Code 211.10(a) Resident care policies. 28 Pa. Code 211.12(d)(3)(5) Nursing services.	F 0689		

Certified End Page

GARVEY MANOR

STATE LICENSE NUMBER: 070202

SURVEY EXIT DATE: 05/01/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY